Medicare Part A (Hospital Insurance) Covers:	What You Pay in 2000* in the Original Medicare Plan
Hospital Stays: Semiprivate room, meals, general nursing and other hospital services and supplies. This does not include private duty nursing, a television or telephone in your room, or a private room, unless medically necessary. Inpatient mental health care coverage in a psychiatric facility is limited to 190 days in a lifetime.	**For each benefit period you pay:** • A total of $776 for a hospital stay of 1-60 days. • $194 per day for days 61-90 of a hospital stay. • $388 per day for days 91-150 of a hospital stay. (See Reserve Days on page 55.) • All costs for each day beyond 150 days.
Skilled Nursing Facility (SNF) Care:** Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies (after a 3-day hospital stay). For more information on SNFs and long-term care (see pages 40 and 50).	**For each benefit period you pay:** • Nothing for the first 20 days. • Up to $97 per day for days 21-100. • All costs beyond the 100th day in the benefit period. If you have questions about SNF care and conditions of coverage, call your Fiscal Intermediary. This is the company that pays Medicare Part A bills (see pages 27-28).
Home Health Care:** Part-time skilled nursing care, physical therapy, speech-language therapy, home health aide services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and supplies, and other services (see pages 40 and 50).	**You pay:** • Nothing for home health care services. • 20% of approved amount for durable medical equipment. If you have questions about home health care and conditions of coverage, call your Regional Home Health Intermediary (see pages 29-30).
Hospice Care:** Medical and support services from a Medicare-approved hospice, drugs for symptom control and pain relief, short-term respite care, care in a hospice facility, hospital, or nursing home when necessary, and other services not otherwise covered by Medicare. Home care is also covered.	**You pay:** • A copayment of up to $5 for outpatient prescription drugs and 5% of the Medicare payment amount for inpatient respite care (short-term care given to a hospice patient by another care giver, so that the usual care giver can rest). The amount you pay for respite care can change each year. If you have questions about hospice care and conditions of coverage, call your Regional Home Health Intermediary (see pages 29-30).
Blood: Given at a hospital or skilled nursing facility during a covered stay.	**You pay:** • For the first 3 pints of blood.

* New Part A and B amounts will be available by January 1, 2001.

** You must meet certain conditions in order for Medicare to cover these services.

If you have general questions about Medicare Part A, call your Fiscal Intermediary. This is the company that pays Medicare Part A bills (see pages 27-28).

Medicare Part B (Medical Insurance) Covers:	What You Pay in 2000* in the Original Medicare Plan
Medical and Other Services: Doctors' services (except for routine physical exams), outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery center facility fees for approved procedures, and durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Also covers outpatient physical and occupational therapy including speech-language therapy, and mental health services.	**You pay:** • $100 deductible (pay once per calendar year). • 20% of approved amount after the deductible, except in the outpatient setting. (See question 12 on page 47.) • 20% for all outpatient physical and speech therapy services and 20% for all outpatient occupational therapy services. • 50% for most outpatient mental health.
Clinical Laboratory Service: Blood tests, urinalysis, and more.	**You pay:** • Nothing for services.
Home Health Care:** Part-time skilled care, home health aide services, durable medical equipment when supplied by a home health agency while getting Medicare covered home health care, and other supplies and services.	**You pay:** • Nothing for services. • 20% of approved amount for durable medical equipment.
Outpatient Hospital Services: Services for the diagnosis or treatment of an illness or injury.	**You pay:** • 20% of the charged amount (after the deductible). During the year 2000, this will change to a set copayment amount.
Blood: Pints of blood needed as an outpatient, or as part of a Part B covered service.	**You pay:** • For the first 3 pints of blood, then 20% of the approved amount for additional pints of blood (after the deductible).

* New Part A & B amounts will be available by January 1, 2001.

** You must meet certain conditions in order for Medicare to cover these services.

Note: Actual amounts you must pay are higher if the doctor does not accept assignment (see page 47). If you have general questions about your Medicare Part B coverage, call your Medicare Carrier. This is the company that pays Medicare Part B bills (see pages 23-24).

Medicare Part B Covered Preventive Services	Who is covered...	What you pay...
Bone Mass Measurements: Varies with your health status.	Certain people with Medicare who are at risk for losing bone mass.	20% of the Medicare approved amount after the yearly Part B deductible.
Colorectal Cancer Screening: • Fecal Occult Blood Test - Once every year. • Flexible Sigmoidoscopy - Once every four years. • Colonoscopy - Once every two years if you are high risk for cancer of the colon. • Barium Enema - Doctor can substitute for sigmoidoscopy or colonoscopy.	All people with Medicare age 50 and older. However, there is no age limit for having a colonoscopy.	No coinsurance and no Part B deductible for the fecal occult blood test. For all other tests, 20% of the Medicare approved amount after the yearly Part B deductible.
Diabetes Monitoring: Includes coverage for glucose monitors, test strips, lancets, and self-management training.	All people with Medicare who have diabetes (insulin users and non-users).	20% of the Medicare approved amount after the yearly Part B deductible.
Mammogram Screening: Once every year.	All women with Medicare age 40 and older.	20% of the Medicare approved amount with no Part B deductible.
Pap Smear and Pelvic Examination: (Includes a clinical breast exam) Once every three years. Once every year if you are high risk for cervical or vaginal cancer, or if you are of childbearing age and have had an abnormal Pap smear in the preceding three years.	All women with Medicare.	No coinsurance and no Part B deductible for the Pap smear (clinical laboratory charge). For doctor services and all other exams, 20% of the Medicare approved amount with no Part B deductible.
Prostate Cancer Screening: Starting January 1, 2000 • Digital Rectal Examination - Once every year. • Prostate Specific Antigen (PSA) Test - Once every year.	All men with Medicare age 50 and older.	Generally, 20% of the Medicare approved amount after the yearly Part B deductible. No coinsurance and no Part B deductible for the PSA Test.
Vaccinations: • Flu Shot - Once every year. • Pneumonia Shot - One may be all you ever need, ask your doctor. • Hepatitis B Shot - If you are at medium to high risk for hepatitis.	All people with Medicare.	No coinsurance and no Part B deductible for flu and pneumonia shots if the doctor accepts assignment (see page 47). For Hepatitis B shots, 20% of the Medicare approved amount after the Part B deductible.